LETTERS TO THE EDITOR

Biological Considerations With Pelvic Neoplasms

Dear Sir,

I would like to comment on the review article by Spratt and Meyer entitled "Biological Considerations with Pelvic Neoplasms" [1].

Their concepts can be extended from patients with pelvic neoplasms to a large proportion of patients with gastrointestinal cancer. Patients with gastric cancer, pancreatic cancer and low colorectal malignancy have "spread predominant" patterns of surgical treatment failure. The unfortunate outcome is that the majority of patients either die or undergo prolonged suffering as a result of cancer dissemination at the resection site or on abdominal and pelvic surfaces.

These "spread predominant" patterns of failure should be contrasted to the "metastases predominant" patterns of failure seen with breast cancer, melanoma and many other malignancies.

Supraradical surgery is not indicated in metastases predominant malignancies. However, it is indicated in spread predominant diseases. It should be combined with perioperative intraperitoneal chemotherapy in many patients, to eliminate small-volume peritoneal seeding or surgically induced microscopic residual disease [2–5].

As oncologic surgeons, we have been far too complacent in accepting the high local recurrence rates with gastric cancer, pancreatic cancer and low colorectal malignancy. Retroperitoneal sarcoma is a rarer cancer that should be included in this category [6,7]. With proper techniques for cancer resection and the use of perioperative intraperitoneal chemotherapy in selected patients, the incidence of resection site recurrence and peritoneal carcinomatosis/sarcomatosis should be reduced to near zero. For example, in gastric cancer, the only recurrence that should be tolerated with modern gastric cancer surgery is liver metastasis [8]. This must be the goal of all gastrointestinal cancer surgery. In addition, local and regional recurrences should be monitored, to maintain proper credentialing of surgeons who treat patients with gastrointestinal malignancies [9,10].

REFERENCES

1. Spratt JS, Meyer JS: Biological considerations with pelvic neoplasms. J Surg Oncol 1999;71:198–205.
2. Cunliffe WJ, Sugarbaker PH: Gastrointestinal malignancy: Rationale for adjuvant therapy using early postoperative intraperitoneal chemotherapy (EPIC). Br J Surg 1989;76:1082–1090.
3. Sugarbaker PH, Graves T, DeBruijn EA, et al.: Rationale for early postoperative intraperitoneal chemotherapy (EPIC) in patients with advanced gastrointestinal cancer. Cancer Res 1990;50:5790–5794.
4. Sugarbaker PH: Peritonectomy procedures. Ann Surg 1995;221: 29–42.
5. Sugarbaker PH, Ronnett BM, Archer A, et al.: Pseudomyxoma peritonei syndrome. Adv Surg 1997;30:233–280.
6. Berthet B, Sugarbaker TA, Chang D, et al.: Quantitative methodologies for selection of patients with recurrent abdominopelvic sarcoma for treatment. Eur J Cancer 1999;35:413–419.
7. Sugarbaker PH: Intraperitoneal chemotherapy and cytoreductive surgery for the prevention and treatment of peritoneal carcinomatosis and sarcomatosis. Semin Surg Oncol 1998;14:254–261.
8. Yu W, Whang I, Averbach A, et al.: Prospective randomized trial of early postoperative intraperitoneal chemotherapy as an adjuvant to resectable gastric cancer. Ann Surg 1998;223:347–357.
9. Sugarbaker PH: Management of peritoneal surface malignancy using intraperitoneal chemotherapy and cytoreductive surgery. In "A Manual for Physicians and Nurses" (3rd ed.). Grand Rapids, MI: Ludann, 1998.
10. Sugarbaker PH: Successful management of microscopic residual disease in large bowel cancer. Presented at Bristol-Myers Squibb Nagoya International Cancer Treatment Symposium, September 11–12, 1998, Nagoya, Japan.

Paul H. Sugarbaker, MD, FACS*
Center for Surgical Oncology
Washington Cancer Institute
Washington, DC

*Correspondence to: Paul H. Sugarbaker, MD, Washington Cancer Institute, Center for Surgical Oncology, 110 Irving Street, NW, Washington, DC 20010-2975. Fax No.: (202) 877-8602.
E-mail: sap6@mhg.edu

Reply

Further insights into patterns of spread and the biological behavior of many neoplasms is becoming more of a science. We have a great deal to learn as we begin to correlate the genetic and molecular biological properties of cancer cells with the behavior of the cancers that they induce.

John S. Spratt, MD, FACS†
Division of Surgical Oncology
University of Louisville Health Sciences Center
Louisville, Kentucky

†Correspondence to John S. Spratt, MD, James Graham Brown Cancer Center, University of Louisville, 529 S. Jackson St., Louisville, KY 40202. Fax No.: (502) 583-4369.
E-mail: jsspra01@ulkyum.louisville.edu